

EXHIBIT F

Amended
11/04/2022

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

2022-019668
STATE FILE NUMBER

NAME OF DECEDENT
Alvis Ray Shrewsbury

1. DECEDENT'S LEGAL NAME (include AKA's if any) (First, Middle, Last) Alvis Ray Shrewsbury		2. GENDER Male	3. SOCIAL SECURITY NUMBER [REDACTED]	
4a. AGE (Last Birthday) (Years) 45	4b. IF UNDER 1 YEAR Months Days Hours Minutes	4c. IF UNDER 1 DAY Hours Minutes	5. DATE OF BIRTH (MM/DD/YYYY) [REDACTED]	
6. BIRTHPLACE (City and State or Foreign Country) Mullens, West Virginia				
7a. RESIDENCE (STATE) West Virginia		7b. COUNTY Wyoming		7c. CITY OR TOWN Bud
7d. STREET AND NUMBER 3917 Herndon Road		7e. APT. NO.	7f. ZIP CODE 24716	7g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT.		STREET & NUMBER APT. NO. CITY OR TOWN COUNTY STATE ZIP		
8. EVER IN US ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		9. MARITAL STATUS AT TIME OF DEATH <input type="checkbox"/> Married <input type="checkbox"/> Married, but separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Unknown		
10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)		11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Willie Shrewsbury		
12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) Anna Lou Perry		13a. INFORMANT'S NAME Miranda Dawn Smith		
13b. RELATIONSHIP TO DECEDENT Daughter		13c. MAILING ADDRESS (Street and Number, City, State, Zip Code) PO Box 303, Bud, WV, 24716		
14. PLACE OF DEATH (Check only one: see instructions)				
IF DEATH OCCURRED IN A HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Emergency Room/Outpatient <input type="checkbox"/> Dead on Arrival <input type="checkbox"/> Hospice facility <input type="checkbox"/> Nursing home/Long term care facility <input type="checkbox"/> Decedent's home <input type="checkbox"/> Other (Specify):				
15. FACILITY NAME (If not institution, give street & number) Beckley Appalachian Regional Hospital		16. CITY OR TOWN, STATE, AND ZIP CODE Beckley, West Virginia 25801		17. COUNTY OF DEATH Raleigh
18. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Entombment <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify):		19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.) Thomas Wayne Shrewsbury Cemetery		
20. DISPOSITION LOCATION (City, State) Stephenson, WV		21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY Stafford Family Funeral Home 143 Cler Fork Road, Oceana, West Virginia, 24870		
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶ Jerry Ray Stafford		23. LICENSE NUMBER (Of Licensee) 3761		
24. DATE PRONOUNCED DEAD (MM/DD/YYYY) 09/17/2022		25. TIME PRONOUNCED DEAD 02:07 AM		
26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.) ▶ Mark Caldwell Geary II		27. DATE SIGNED (MM/DD/YYYY) 09/19/2022		
28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) 09/17/2022 Actual		29. ACTUAL OR PRESUMED TIME OF DEATH 02:07 AM Actual		30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes CASE # 2206566
CAUSE OF DEATH				
31. PART I. Enter the chain of events -- diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute and chronic upper gastrointestinal bleeding				
Due to (or as a consequence of):				
b. <<<<>>>>				
Due to (or as a consequence of):				
c. <<<<>>>>				
Due to (or as a consequence of):				
d. <<<<>>>>				
PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I. Cardiomegaly				
32a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
33. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		34. IF FEMALE <input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the last year		35a. CAUSE/MANNER PENDING? <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Date Amended 11/04/2022 See 35b. for Final Manner of Death
35b. FINAL MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				
36a. DATE OF INJURY (MM/DD/YYYY)		36b. TIME OF INJURY		36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area)
36d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
36e. LOCATION OF INJURY: Street & Number: Apt No.: City or Town: State or Country: Zip Code:				
36f. DESCRIBE HOW INJURY OCCURRED				
36g. IF TRANSPORTATION INJURY: SEATBELT RESTRAINT STATUS: ROLE: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Restraint <input type="checkbox"/> No restraint <input type="checkbox"/> Unknown HELMET STATUS: <input type="checkbox"/> Helmet <input type="checkbox"/> No helmet <input type="checkbox"/> Unknown				
37a. CERTIFIER (Check only one): <input type="checkbox"/> Certifying Physician or Qualified APRN / PA - To the best of my knowledge, death occurred due to the cause(s) and manner stated. <input type="checkbox"/> Pronouncing & Certifying Physician or Qualified APRN / PA - To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. <input checked="" type="checkbox"/> Medical Examiner/Coroner - On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.				
Signature of Certifier ▶ Paul Mellen Electronically Signed Date Certified 09/19/2022				
37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.) Paul Mellen 619 Virginia Street W, Charleston, WV 25302				
37c. TITLE OF CERTIFIER Medical Examiner				
38. FOR OFFICIAL REGISTRAR USE ONLY - SIGNATURE OF REGISTRAR ▶ Matthew Wickert Electronically Signed				
39. FOR OFFICIAL REGISTRAR USE ONLY - DATE FILED 09/30/2022				

DATE/
TIME
OF DEATH
MUST BE
COMPLETED

TYPE/PRINT
IN
PERMANENT
BLACK
INK

PHYSICIAN, QUALIFIED APRN / PA OR NON-PHYSICIAN CORONER

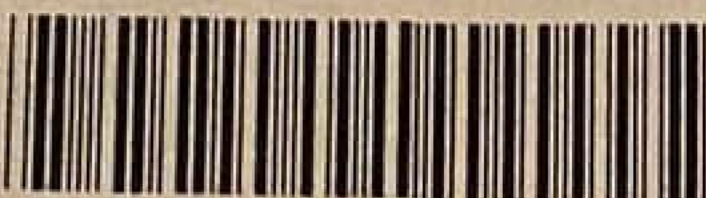
MEDICAL EXAMINER OR
CORONER ONLY

PHYSICIAN, QUALIFIED APRN /
PA, OR CORONER ONLY

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Vital Statistics
Bureau for Public Health
West Virginia Department of Health and Human Resources
Charleston, West Virginia.

Matthew R. Wickert

Matthew R. Wickert
State Registrar

Date Certified: Nov 09 2022

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